Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Gastrointestinal services in India during COVID-19: does governance matter?

During the first wave of COVID-19 in India, when the majority of hospitals were converted into exclusive COVID centres, it was astonishing to see the performance of the Department of Gastroenterology, Kovai Medical Center and Hospital, Tamil Nadu, India.[1] This hospital is part of the private sector, with an autonomous governing body responsible for making policy decisions. Although there were directives from the central government regarding functioning of hospitals during the pandemic, private hospitals could make their own decisions about priorities.

A recent multicentre study on the impact of the first wave of the COVID-19 pandemic on cancer care in India demonstrated a highly compromised service.[2] In this study, public hospitals had larger reductions in patient numbers and their related services than private hospitals between March and May, 2020, compared with the same period in 2019. For instance, more patients received external beam radiotherapy at private hospitals in 2020 compared with 2019 (4%), whereas there were large reductions over the same time period in public (33%) and charitable (43%) hospitals. This demonstrates the different results between private and public sector hospitals in India, which needs urgent further exploration. Although the functioning and structure of private and public hospitals are somewhat similar, there is a difference in the governance and leadership at a high level. The governing bodies of public hospitals often comprise mostly ministers and leaders from the central or state government political parties and generally have limited medical background and experience. By contrast, the governance bodies at private hospitals comprise medical professionals—as reported by Ramakrishnan and colleagues,[1] where the chairman is a renowned health professional. Hence, governance is perhaps a major reason for such divergent results and needs immediate attention.

We would also like to bring attention to the importance of differentiating between patients who had been referred and those who presented directly to the hospital in Ramakrishnan and colleagues' report. Gastroenterology services are super-specialty facilities in India and many patients using these services are referred from private clinics. Thus, differentiation of patients into those referred and those who present directly is of vital importance. This information will indirectly reveal the active/inactive status of the surrounding small clinics, which cater to a large number of patients on a day-to-day basis.

We declare no competing interests.

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Authors' reply

We thank Gargi Sarode and Sachin Sarode for their interest in our recent Correspondence.[1] As a designated COVID-19 hospital (and the largest non-governmental COVID-19 hospital in our city[2]), neither non-enforcement of government directives nor referral pattern (both before the pandemic and during it, we received less than 10% of referrals

from private clinics, who had curtailed work during COVID-19[3]) contributed to our results.[1] Our proximity to Kerala (where the first COVID-19 case in India was reported in January, 2020), being one of the first COVID-19 hospitals in the state of Tamil Nadu, and liasion with our UK colleagues gave us an early advantage in establishing clinical governance protocols for a COVID-19-free pathway by segregating services and enabling risk mitigation strategies for health-care workers and patients. Given that one in five endoscopies contributed to a new diagnosis requiring immediate attention or therapeutic interventions, together with a significant increase in cancer detection, endoscopy is essential. Our strategy of pre-endoscopy SARS-CoV-2 testing not being mandatory contributed to our results. Similar results have been achieved by Indian charitable centres with the philosophy that specialists are available to care for their patients regardless of COVID-19.[4] The belief of our clinical and management teams in this philosophy, and a hospital system able to contract and expand to adapt to the needs of the pandemic was a privilege.

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Hepatitis C virus in sub-Saharan Africa: a long road to elimination

The development of direct-acting antivirals against hepatitis C virus (HCV) has transformed the treatment landscape and underpinned the WHO goal of HCV elimination by 2030. However, as of 2021, few countries remain on track to achieve this goal. Reliable data remain scarce, especially those on national plans for HCV elimination in many regions of the world and particularly in sub-Saharan Africa, which accounts for around 11 million of 71 million people estimated to be living with HCV.[1]

We did a survey of the membership in the HCV sub-Saharan Africa Network, consisting of blood transfusion service experts and lead physicians for HCV treatment to gain an understanding of the size of the challenge that sub-Saharan Africa faces. The network was developed through funding from the Global Challenges Research Fund by the Scottish Funding Council. This collaboration resulted in the development of a network of 25 senior treating physicians across 13 countries, many of whom are head of their national viral hepatitis programmes, and 13 blood transfusion service experts across 12 countries.

Physicians and blood transfusion service experts responded to separate surveys via REDCap, a secure electronic data capture tool hosted at the University of Glasgow. Surveys were distributed in English and French. Questions on the survey covered the availability of diagnostic tests, direct-acting antivirals, and associated costs. Participants were also asked what they thought were the main risk factors for HCV transmission in their countries. Survey responses were received from 20 physicians representing ten countries and six blood transfusion service experts representing five countries. Ten countries were represented in total.

Most countries (nine [90%] of ten) reported that cultural practices contributed to HCV infection, which has been shown in Ghana, where tribal scarification and traditional male circumcision procedures were associated with higher risks of HCV infection.[2] Most countries also reported that health-care-associated activities were likely to have contributed to HCV infection. Three (30%) countries reported injecting drug use as a substantial risk factor. A rising epidemic of injecting drug use, in particular heroin, along the east coast of Africa was shown to be associated with HCV infection.[3] Importantly, four (40%) countries reported that there were unknown factors contributing to HCV infection, thus highlighting the need for more exhaustive epidemiology studies.

Availability of direct-acting antivirals varied, but the most commonly available regimens among countries participating in this survey included the first generation NS5A inhibitors, daclatasvir (90%) and ledipasvir (70%). Five (50%) countries reported having access to the second generation NS5A inhibitor velpatasvir, and none of the countries had access to protease inhibitor-based regimens or alternative NS5A inhibitors. Although the overall effectiveness of direct-acting antivirals in a real-world setting is excellent, some HCV subtypes are more challenging to treat. For example, 1l and 4r subtypes were shown to have poor rates of sustained virological response at 12 weeks post-treatment when patients were given sofosbuvir–ledipasvir,[4,5] and these

For more on the **REDCap** see https://www.project-redcap.org/